Maine Breast and Cervical Health Program (MBCHP)

Abnormal Cervical Screening Follow-Up Report

•This form has been generated by the MBCHP based on a reported abnormal cervical screening result. Please document the results of the diagnostic follow-up for this abnormal result on this form and return to the MBCHP. Please include copies of all diagnostic reports.
•If results are pending, please update this form with additional information when received and resubmit it to the MBCHP.

Provider Site:_____ **Date of abnormal screening exam:** __ __ / __ __ / __ __ __ _

Patient Name (Last, First, M. I.):_____

Consent for release of information on this client is on file at the MBCHP. Available upon request at 1-800-350-5180.

REASONS FOR WORK-UP (check all that apply)

□ Abnormal Pap □ Abnormal Pelvic Exam

DIAGNOSTIC PROCEDURES (check all that apply with dates)

□ Colposcopy without biopsy
Date:__ __ / __ __ / __ __ __ __Provider:_____

□ Colposcopy - directed biopsy
Date:__ __ / __ __ / __ __ __ __Provider:_____

□ *Surgical consult/referral
Date:__ __ / __ __ / __ __ __ __Provider:_____

Other Diagnostic Procedures:

□ Removal of cervical polyp (not covered)

□ *Repeat Pap

□ *Other
(specify):_____
Date:__ __ / __ __ / __ __ __ __
Provider:_____

*Please send copies of these reports

STATUS OF DIAGNOSIS

□ Work-Up Complete
□ *Work-Up Pending
□ Lost to Follow-Up (give specific date: __ __ / __ __ / __ __ __ __)
□ Work-Up Refused (give specific date: __ __ / __ __ / __ __ __ __)

*If work-up is pending, please update this form with additional information when received and resubmit to MBCHP.

FINAL DIAGNOSIS

Date of diagnosis: __ __ / __ __/ __ __ __ __ (This is the date the definitive diagnostic procedure was performed)

□ Normal/benign reaction/inflammation
□ HPV/condylomata/atypia (low grade SIL)
□ CIN I/mild dysplasia (low grade SIL)
□ *CIN II/moderate dysplasia (high grade SIL)
□ *CIN III/severe dysplasia/carcinoma in situ (high grade SIL)
□ *Invasive Cervical Carcinoma
□ Other diagnosis (specify):_____

Stage at Diagnosis (if known):_____
(for all HSIL and greater)

Recommended rescreening date: __ __ / __ __/ __ __ __ __

*Diagnoses requiring treatment (complete treatment section below)

□ Request MBCHP Case Management
(for assistance in managing patient care)

TREATMENT

□ Treatment Not Needed
□ Treatment pending (specify procedure) _____
Date: __ __ / __ __/ __ __ __ __Provider: _____
□ Treatment started (specify procedure) _____
Date: __ __ / __ __/ __ __ __ __Provider: _____
□ Lost to Follow-up (includes deceased)
Date: __ __ / __ __/ __ __ __ __
□ Treatment Refused
Date: __ __ / __ __/ __ __ __ __

Notes: _____

_____

Please return this form to: MBCHP, 11 State House Station, Augusta, ME 04333
Phone: 1-800-350-5180 Fax: 1-800-325-5760 or 287-4100